MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

9-d 04491

Reg. Dist. No. 351

1. PLACE OF DEATH:

County: Worcester md

City or town: Newark md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Worcester

City or town: Newark Md (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION) no

2.(a) If veteran, name war:

3. (a) FULL NAME: Alice Bethards

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a.a.	Single

6.(b) Name of husband or wife: no

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1867

8. AGE: Years: 80 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Newark Md (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Same as above

FATHER — 12. Name: George E Bethards

FATHER — 13. Birthplace: Newark

MOTHER — 14. Maiden name: Millie Bethards

MOTHER — 15. Birthplace: Newark md

16. Informant: Mrs Martha Timmons

Address: Berlin md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 5 (month) (day) 1947 (year)

Cemetery or crematory: Bunkonca

Location: Bunkonca nr Newark

18. Funeral director: James H. Stewart

Address: Salisbury Md

19. 5/5/47 (Date rec'd by registrar) Reloy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-1-47 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-46 19..... to 5-1-47 19.....

aed that I last saw h... alive on 4-26-47 19.....

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ✓

Date of op.

Autopsy results: ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ✓ Injured at work? —

23. SIGNATURE: Clifford E Schott M. D. or other

Address: Berlin Md Date signed: 5-7-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

117a

04492

CERTIFICATE OF DEATH

Reg. Dist. No. 350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Worcester

City or town: Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 42

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Worcester

City or town: Pocomoke City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME Mrs Annie B. Cluff

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: ✓

6.(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): January 18, 1867

8. AGE:

Years	Months	Days	If less than one day
80	4	0	...hrs. ...min.

9. Birthplace: Pocomoke, Somerset, Md (Town, county, and state)

10. Usual occupation: Keeping own home

11. Industry or business

FATHER

12. Name: Robert W. Cluff

13. Birthplace: Md

MOTHER

14. Maiden name: Irene Broughton

15. Birthplace: Md

16. Informant: Miss Mazie Cluff

Address: Pocomoke City, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 21, 1947 (month) (day) (year)

Cemetery or crematory: Episcopal St. Mary's

Location: Pocomoke city, Md

18. Funeral director: Margarette A. Watson

Address: Pocomoke city, Md.

19. May 19 1947 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1947, at 11:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13th 1947, to May 18 1947

and that I last saw h... alive on May 18 1947

Immediate cause of death: Myocardial degeneration

Due to: Senility

Due to: Gastric Ulcer

Other conditions:

	DURATION
Myocardial degeneration	2 days
Senility	
Gastric Ulcer	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. G. Litsinger M. D. or other

Address: Date signed: 5-18-47

04493

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:
County WORCESTER
City or town SNOW HILL RURAL #2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 64 YRS
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County WORCESTER
City or town SNOW HILL MD RURAL #2
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME THOMAS EDWARD DALE

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	COLORED	MARRIED

6.(b) Name of husband or wife WAFFIE DALE
6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) MARCH 16 1883

8. AGE: Years	Months	Days	If less than one day
64	1	22	hrs. min.

9. Birthplace SNOW HILL WORCESTER MD.
(Town, county, and state)
10. Usual occupation FARMER
11. Industry or business

FATHER
12. Name SAMUEL DALE
13. Birthplace MARYLAND

MOTHER
14. Maiden name UN KNOWN
15. Birthplace

16. Informant JESSIE DALE
Address SNOW HILL MD RURAL #2
17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 5-11-1947 (month) (day) (year)
Cemetery or crematory FRIENDSHIP
Location SNOW HILL MD RURAL #2
18. Funeral director CLAYE DENNIS
Address SNOW HILL MD
19. 5/10 1947 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 9 1947 at 1 15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from NOV. 18 1946 to MAY 9 1947 and that I last saw him alive on MAY 8 1947

Immediate cause of death	DURATION
CEREBRAL VASCULAR ACCIDENT	7 DAYS
Due to HYPERTENSIVE CARDIO-VASCULAR RENAL DISEASE	10 YRS
Due to	
Other conditions CHRONIC CONGESTIVE CARDIAC FAILURE	6 MOS.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert L. LeMay M.D.
M. D. or other
Address Snow Hill Date signed 5-10-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 b

CERTIFICATE OF DEATH

04494 355

Reg. Diat. No.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Worcester
City or town: Whaleyville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Whaleyville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John E Davis

3.(b) Social Security Number

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Sarah Davis
6.(c) If alive, give age: 50 years
7. Birth date of deceased (mo., day, yr.): June 11, 1889
8. AGE: Years: 57 Months: Days: If less than one day: hrs. min.
9. Birthplace: Whaleyville (Town, county, and state)
10. Usual occupation: Former
11. Industry or business: Farming
FATHER 12. Name: John Davis
13. Birthplace: Md.
MOTHER 14. Maiden name: Millie Jones
15. Birthplace: Md
18. Informant: Janie Engle
Address: Whaleyville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20 1947 (month) (day) (year)
Cemetery or crematory: Whaleyville Md
Location: whaleyville Md
18. Funeral director: M. Kesha Watson
Address: Whaleyville Md
19. 5-20 1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1947, at 9 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw him alive on May 16 1947
Immediate cause of death: Chronic myocarditis — DURATION
Due to:
Due to:
Other conditions: Chr nephritis
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas. R. Lowe M.D. M. D. or other
Address: Berlin Md. Date signed 5-19-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

04495

Reg. Dist. No. 355

M

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Worcester.
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 85 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Worcester.
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John Edward Davis.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married.

6.(b) Name of husband or wife Esther Allison Davis
6.(c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1862

8. AGE: Years	Months	Days	If less than one day
85	2	8	hrs. min.

9. Birthplace Berlin Wor Co Md.
(Town, county, and state)
10. Usual occupation Farmer.
11. Industry or business

FATHER
12. Name William T. Davis.
13. Birthplace Maryland.

MOTHER
14. Maiden name Clara Hammond.
15. Birthplace Maryland.

16. Informant Mrs. Albert Davis.
Address Delmar Del.

17. (Burial, cremation, or removal. Which?) Burial Date thereof 5/30/47 (month) (day) (year)
Cemetery or crematory Evergreen.
Location Berlin Md.
18. Funeral director Anna A. Burbage
Address Berlin Md

19. 5/30 1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 May 1947 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 May 1947 to 27 May 1947 and that I last saw h. alive on 27 May 47 19

Immediate cause of death	DURATION
Degenerative myocarditis	2 week
Due to Arteriosclerosis	
Due to senility	
Other conditions Partial hemiplegia	
(Include pregnancy within 3 months of death)	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Hermann Rabkin M.D. M. D. or other
Address 5 Bay St Berlin Md Date signed 30 May 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

04496

Reg. Diat. No. 351

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill, Rural #1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Altha M. Lambertson

3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: John S. Lambertson
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Sept. 20 1869
8. AGE: Years: 77 Months: 8 Days: 0 If less than one day: hrs. min.
9. Birthplace: Pocomoke City, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
12. FATHER Name: Benjamin Ward
13. FATHER Birthplace: Maryland
14. MOTHER Maiden name: Martha Pedden
15. MOTHER Birthplace: Maryland
16. Informant: Mrs. Russell Jones
Address: Stockton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 22 47 (month) (day) (year)
Cemetery or crematory: Woodlawn Methodist
Location: Pocomoke City, Md.
18. Funeral director: Wm. E. Timmons
Address: Snow Hill, Md.
19. 5/20 1947 (Date rec'd by registrar) R. Ray Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1947 at 6 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11 1947, to May 20 1947
and that I last saw her alive on May 25 1947

Immediate cause of death: Acute Pulmonary Edema — DURATION: 1 day
Due to: Acute Coronary Occlusion — 10 days
Due to: Hypertension Cardiovascular Renal syndrome — 5 yrs.
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robt. L. LaMar, M.D. M. D. or other
Address: Snow Hill, Md. Date signed: 5-21-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

04497

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH:
County: Worcester
City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Pocomoke
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: John William Rantz

3.(b) Social Security Number: —

4. Sex: male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Mary B. Rantz
6.(c) If alive, give age: 69 years
7. Birth date of deceased (mo., day, yr.): October 5 1873
8. AGE: Years: 73 Months: 7 Days: 9 If less than one day: hrs. min.
9. Birthplace: Kankakee, Kankakee, Ill. (Town, county, and state)
10. Usual occupation: Veterinarian
11. Industry or business:

FATHER
12. Name: Henry E. Rantz
13. Birthplace: Ill

MOTHER
14. Maiden name: Louise Trimble
15. Birthplace: ~~Canada~~ Canada.

16. Informant: Mrs Jeanette Rantz
Address: Pocomoke Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 18-1947 (month) (day) (year)
Cemetery or crematory: Salem M.E. Colony
Location: Pocomoke Md.
18. Funeral director: Henry Elevation
Address: Pocomoke Md.
19. May 17 1947 (Date rec'd by registrar) Anne E. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1947 at 305 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1946 to May 13 1947
and that I last saw him alive on May 13 1947
Immediate cause of death: Arterio-sclerotic Cardio-Vasc. Disease — DURATION: 1 Yr.
Due to:
Due to:
Other conditions: Hypertrophied Prostate — DURATION: 3 Yrs
(Include pregnancy within 3 months of death)
Major findings of operations: — Date of op.
Autopsy results: None.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lewis L. Llewellyn MD M. D. or other
Address: Pocomoke City Date signed 5-17-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

52b

04498

FILM No. G 116 JUN 3 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH:

County: Worcester

City or town: Berlin (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred: Grace St.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Berlin (If outside city or town limits, write RURAL and give nearest town)

Street No.: Grace St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Helen T. Schmerber

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Fred Schmerber

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 18, 1871

8. AGE: Years	Months	Days	If less than one day
75 76	11 0	9	hrs. min.

9. Birthplace: Berlin, Worcester, Md. (Town, county, and state)

10. Usual occupation: Bookkeeper

11. Industry or business: Ice Mfg.

FATHER — 12. Name: James Parker

FATHER — 13. Birthplace: Berlin, Md.

MOTHER — 14. Maiden name: Eliza J. Toll

MOTHER — 15. Birthplace: Berlin Md.

16. Informant: Alfred Pruitt

Address: Berlin, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 11, 1947 (month) (day) (year)

Cemetery or crematory: Buckingham Cem.

Location: Berlin Md.

18. Funeral director: Anna A. Burbage

Address: Berlin, Md.

19. 5-11- 1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 May 1947 at 7 35 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 March 1947 to 9 May 1947 and that I last saw h... alive on 9 May 47 1947

Immediate cause of death	DURATION
Hypostatic pneumonia	
Due to: Chronic Degenerative Myocarditis	4 yrs.
Due to: Carcinoma of the neck of the bladder	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Hermann Dubbs M.D. M. D. or other

Address: Berlin, Md. Date signed: 5-10-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

167

04580

Reg. Dist. No. 351

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill Rural #1
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3. (a) FULL NAME: James O. Lessons

3. (b) Social Security Number: 213-18-4247

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 16 - 1883

8. AGE: Years: 63 | Months: 5 | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Powellsville, North Carolina
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Rubie H. Lessons
Address: Snow Hill, Md Rural #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 3/47 (month) (day) (year)

Cemetery or crematory: Mt Wesley
Location: Snow Hill, Md

19. Funeral director: Elay E. Dennis
Address: Snow Hill Md

19. 6/2 19 47 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 19 47, at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19, to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Hemorrhage due to a Stab wound in the neck	few minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of: 5/30/47
Where did injury occur? Snow Hill (City or town) Worcester (County) Md (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: Stab wound Injured at work? No

23. SIGNATURE: John L. Riley Dep. Med Exam M. D. or other
Address: Snow Hill Md Date signed: 6/2/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

04499

CERTIFICATE OF DEATH

Reg. Diat. No. 351

1. PLACE OF DEATH:

County: Worcester

City or town: Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 76 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

WITHIN CORPORATE LIMITS OF

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Oliver Perry Simmons

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Grace G. Simmons

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Oct. 29 - 1883

8. AGE:

Years	Months	Days	If less than one day
63	6	18	...hrs. ...min.

9. Birthplace: Golden Hill Dorchester Md

(Town, county, and state)

10. Usual occupation: Retired School Teacher

11. Industry or business:

FATHER

12. Name: Robert Simmons

13. Birthplace: Maryland

MOTHER

14. Maiden name: Umbleton

15. Birthplace:

16. Informant: Mrs. Grace G. Simmons

Address: Snow Hill, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 21/47 (month) (day) (year)

Cemetery or crematory: Whatcoat

Location: Snow Hill, Md

18. Funeral director: Elmer E. Simmons

Address: Snow Hill, Md

19. 5/19 1947 (Date rec'd by registrar) LeRoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1947 at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Myocardial degeneration	
a) Heart	one month
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John L. Riley Dep Med Exam M. D. or other

Address: Snow Hill Md Date signed: 5/18/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

045011

Reg. Diat. No. 9 515

1. PLACE OF DEATH:

County Worcester

City or town Sycamore Grove Near Berlin md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Worcester

City or town Sycamore Grove Near Berlin (If outside city or town limits, write RURAL and give nearest town)

Street No. no (If rural, give LOCATION)

2.(a) If veteran, name war no

3.(a) FULL NAME George Pringle

3.(b) Social Security Number Dont Know

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	a.a.	Married

6.(b) Name of husband or wife Mary A Pringle

Yes 6.(c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.) Apr 4, 1895

8. AGE: Years	Months	Days	If less than one day
52.	1	11	...hrs. ...min.

9. Birthplace Berlin Md (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Same as above

FATHER 12. Name George Morris

13. Birthplace Berlin Md

MOTHER 14. Maiden name Caroline Pringle

15. Birthplace Berlin Md

16. Informant Mary Pringle

Address Berlin Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20-1947 (month) (day) (year)

Cemetery or crematory Townes

Location Sycamore R.F.D. Berlin md

18. Funeral director James F Stewart

Address Salisbury Md

19. 5/20 1947 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 May 1947, at 6:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 May 1947, to 16 May 1947 and that I last saw h-- alive on 16 May 1947

	DURATION
Immediate cause of death Cerebral hemorrhage	25 Hours
Due to Hypertension	Indefinite
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Nathaniel F. Townes M.D. M. D. or other

Address Ocean City, Md Date signed 17 May 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A35 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1312

04502

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill Rural #2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill Rural #2
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION) No
2.(a) If veteran, name war:

3.(a) FULL NAME: Robert Earl Townsend

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 8, 1938

8. AGE: Years: 8 | Months: 10 | Days: 12 | If less than one day: hrs. min.

9. Birthplace: Snow Hill Worcester Md
(Town, county, and state)

10. Usual occupation: School

11. Industry or business:

FATHER
12. Name: George Townsend
13. Birthplace: Maryland

MOTHER
14. Maiden name: Maggie Ayres
15. Birthplace: Maryland

16. Informant: Riley E. Dennis
Address: Snow Hill, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 23/47 (month) (day) (year)
Cemetery or crematory: Taylors Gate
Location: Snow Hill, Md Rural #2

18. Funeral director: Riley E. Dennis
Address: Snow Hill, Md

19. 5/22/47 (Date rec'd by registrar) Riley Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1947 at 5:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Chronic Nephritis — DURATION: 5 mo.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John L. Riley D.O. Med Exam. M. D. or other
Address: Snow Hill Md Date signed 5/22/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

04503

CERTIFICATE OF DEATH

Reg. Dist. No. 351

WITH CORRECTED DEATH CERTIFICATE

1. PLACE OF DEATH:
County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 80 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: James B. Truitt

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Lydia Truitt
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 3 - 1857

8. AGE: Years: 89 | Months: 8 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Parsonsburg Wicomico, Md
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business:

FATHER
12. Name: Zedekiah Truitt
13. Birthplace: Maryland

MOTHER
14. Maiden name: Gertrude Towns
15. Birthplace: Maryland

16. Informant: Miss Inbmkey Truitt
Address: Snow Hill Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 3/47 (month) (day) (year)
Cemetery or crematory: Baptist
Location: Snow Hill Md

18. Funeral director: Clay E. Dennis
Address: Snow Hill, Md

19. 6/2 1947 (Date rec'd by registrar) LeCoy Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 19 47, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 45, to May 30 19 47
and that I last saw him alive on 5/30/47 19

Immediate cause of death	DURATION
Congestive Heart Failure	1 day
Due to: Arteriosclerotic	
Hypertensive Cardio-renal	
Due to: disease	unknown
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul Cohen M.D.
M. D. or other
Address: Snow Hill Date signed: 5/31/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9.45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

04504

CERTIFICATE OF DEATH

Reg. Dist. No. 354

1. PLACE OF DEATH:

County Worcester

City or town Near Stockton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County Accomac

City or town Grunbackville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME. William J. Ward

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widower

6.(b) Name of husband or wife Jennie Ward

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1870

8. AGE:

Years	Months	Days	If less than one day
76	6	13	hrs. min.

9. Birthplace Accomack Co. Va.

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Ira Ward

13. Birthplace Md.

MOTHER 14. Maiden name Mary Melvin

15. Birthplace Md

16. Informant

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 11, 1947 (month) (day) (year)

Cemetery or crematory

Location Greenbackville, Va

18. Funeral director N. A. Shields

Address New Church, Va

19. May 11, 1947 (Date rec'd by registrar) Mary M. Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1947 at 7:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Cerebral hemorrhage	Few minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

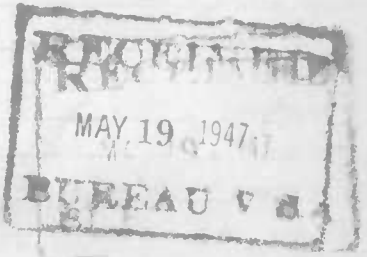
23. SIGNATURE John L. Riley Dep. Med Examr M. D. or other

Address Snow Hill Md Date signed 5/8/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


MAY 19 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

04505

Reg. Diat. No. 955

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Worcester.

City or town Snowhill Berlin R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 86 years.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Worcester.

City or town Snowhill Berlin R.F.D.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME William Thomas Warren.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Jennie Warren.

6.(c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) May 12 1861

8. AGE: Years	Months	Days	If less than one day
86	0	6	hrs. min.

9. Birthplace Snowhill Berlin Md R.F.D.
(Town, county, and state)

10. Usual occupation Farmer.

11. Industry or business

FATHER 12. Name Albert Warren

13. Birthplace Berlin Md.

MOTHER 14. Maiden name Mary Rayne.

15. Birthplace Berlin Md

16. Informant Miss Mary Warren

Address Berlin Md R.F.D.

17. (Burial, cremation, or removal. Which?) Burial Date thereof 5/20/47 (month) (day) (year)

Cemetery or crematory Evergreen

Location Berlin Md

18. Funeral director Anna A. Bunting

Address Berlin Md

19. 5/20 19 47 (Date rec'd by registrar) Helen F. Hayward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-18-47 19 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-35 19 to 5-18-47 19 and that I last saw h.. m. alive on 5-15-47 19

	DURATION
Immediate cause of death Chronic Myocarditis	1935
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clifford E. Schott M. D. or other

Address Berlin Md Date signed

Evidence for the addition of place of residence is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

FILM No. G 11[illegible] JUN 10 1947 **CERTIFICATE OF DEATH**

04506 353
Reg. Dist. No. Cert. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name and address. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Worcester
City or town Whaleyville R.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Worcester
City or town Whaleyville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Martha Ellen Whaley

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Married

6.(b) Name of husband or wife Clarence Whaley
6.(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Apr. 12, 1883

8. AGE: Years 64 | Months 1 | Days 17 | If less than one day ..... hrs. ..... min.

9. Birthplace Delaware
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Joshua Rogers
13. Birthplace Del.

MOTHER 14. Maiden name Hennie Rogers
15. Birthplace Del.

16. Informant Clarence W. Whaley
Address Whaleyville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 1, 1947 (month) (day) (year)

Cemetery or crematory Rogers Cemetery
Location near Williamsville Fire
18. Funeral director Henry N. Watson
Address Pocomoke City, Md.

19. 5/31/1947 (Date rec'd by registrar) Mrs. Roy Bugay Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1947, at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw her alive on May 29- 1947

Immediate cause of death	DURATION
Due to Chronic Brights	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Chas. R. Low M. D. or other
Address Berlin Md. Date signed 5-31-47